Appendix 3
Prior Authorization Alcohol and Other Drug Abuse Attachment (PA/AA) Completion Instructions

To avoid delays in prior authorization (PA) request approval, providers should ensure that all clerical information is correctly entered on the Prior Authorization Request Form (PA/RF) and that all clinical information necessary to document that the service is medically necessary is included. Carefully complete the Prior Authorization Alcohol and Other Drug Abuse Attachment (PA/AA), attach it to the PA/RF, and submit it to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Questions regarding the completion of the PA/RF and/or the PA/AA may be directed to Provider Services at (800) 947-9627 or (608) 221-9883.

Recipient Information

Element 1 — Last Name
Enter the recipient's last name. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — First Name
Enter the recipient's first name. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Middle Initial
Enter the recipient's middle initial from the recipient's identification card.

Element 4 — Medical Assistance ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 5 — Age
Enter the age of the recipient in numerical form (e.g., 21, 45, 60)

Provider Information

Element 6 — Performing Provider's Name and Credentials
Enter the name and credentials of the therapist who will be providing treatment.

Element 7 — Performing Provider's Medical Assistance Provider Number (not required)

Element 8 — Performing Provider's Telephone Number
Enter the performing provider's telephone number, including area code.

Element 9 — Referring/Prescribing Provider's Name
Enter the name of the provider referring/prescribing treatment.

Element 10 — Referring/Prescribing Provider's Medical Assistance Number

Enter the referring/prescribing provider's eight-digit provider number, if available. The remaining portion of this attachment is to be used to document the medical necessity for the service requested.

- **Part A — Type of Treatment Requested**
  Designate the type of treatment requested (e.g., primary intensive outpatient treatment, aftercare/follow-up service, or affected family member/codependency treatment). Identify the types of sessions, duration, and schedule. The total hours must match the quantities indicated on the PA/RF.

If a certified psychotherapist is requesting specific *psychotherapy* services for the substance abuse (alcohol and other drug abuse)-affected recipient that are not represented by the categories of treatment listed, complete the Prior Authorization Psychotherapy Attachment (PA/PSYA).

- **Part B**
  Providers may attach copies of assessments, treatment summaries, treatment plans or other documentation in response to the information requested on the form. Providers are responsible for ensuring that the information attached adequately responds to what is requested.

1. Attach a copy of the signed and dated prescription for substance abuse services (unless the physician is the performing provider). The initial prescription must be signed and dated within three months of receipt by Medicaid. Subsequent prescriptions must be dated within twelve months of receipt by Wisconsin Medicaid.
2. Read the 'Prior Authorization Statement' before signing and dating the attachment.
3. The recipient's signature is optional.
4. The attachment must be signed and dated by the provider requesting/providing the service.

   Note: The name and signature of the supervising provider is not required if the performing provider is a physician or psychologist.